Child and Adolescent Mental Health Division

Consent to Evaluation/Treatment

Name of Consumer (Last Name, First Name and Middle Name)	Birthdate - MM/DD/YY
Name and Address of Person to Provide Treatment	

☐ Consent to Evaluation Only ☐ Consent to Initial Treatment ☐ Consent to Develop a Comprehensive Treatment Plan

Conditions to be treated, including diagnosis or probable diagnosis:

Purpose(s) of proposed treatment or recommended procedures:

Specific treatment(s) proposed:

Summary of recognized benefits and risks of the proposed treatment and alternatives, including no treatment, and anticipated results of treatment which are verbally explained.

`Start here, if you need more space, add an additional page.`

For the person(s) providing consent:

- ☐ (Initial Consent Only) The booklet on my rights was given and explained to my satisfaction, including the name of my Rights Advisor.
- ☐ I hereby consent to the evaluation/treatment proposed above.
- ☐ I was able to ask questions and receive answers about this proposed treatment.
- ☐ I understand that I may obtain a second opinion.
- ☐ I understand that I may withdraw my consent prior to or during treatment.
- ☐ I understand that the anticipated result of treatment is not guaranteed.
- ☐ I understand that certain records about me/my child and my/my child's treatment shall be kept in written and computerized form.

Printed Name of person(s) providing consent:	Relationship to consumer

Signature(s) of person(s) providing consent:	Date:

Name (Printed and Signature) of staff person providing information and obtaining consent

	Title of Person:	Date:

This consent expires on this date:

This consent is withdrawn effective this date: _____

Signature of parent/guardian:

CAMHD P&P 80.401 – Attachment A